BUILDING INDUSTRY MEDICAL AID FUND, EAST CAPE

(Registered under the Labour Relations Act, 1995)

F.G. Black Building 169 Haupt Street SIDWELL PORT ELIZABETH 6001

MEMBERSHIP APPLICATION

Private Bag 4089 KORSTEN PORT ELIZABETH

Telephone No: 041 453 2751

IMPORTANT Failure to disclose material information or the provision of incorrect information can result in the immediate

6014

041 405 1900		cancellation of your membership. Failure to complete or	For Office Use Only			
Fax No: 086 517 2679 E-mail: medicalaid@bibcpe	0.00.79	submit all information required, WILL delay processing of your application for membership of the Fund.				
L-man. medicalald@blocpe	.co.za	your application for inclinership of the rund.				
APPLICANT'S SURNAME:						
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FULL FIRST NAME(S):						
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POSTAL ADDRESS:						
TOSTAL ADDRESS.						
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RESIDENTIAL ADDRESS:						
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		MARITAL STATUS:	MEMBER TYPE:			
		SINGLE	STAFF			
		SINGLE	SIAFF			
		MARRIED WITH ONE DEPENDANT	COMPULSORY			
		MARRIED WITH MORE THAN ONE DEPENDANT	VOLUNTARY			
			ADDDENITICE			
			APPRENTICE			
			PENSIONER			
		GENDER:	WIDOW			
		MALE	WIDOW			
		FEMALE	OFFICE USE ONLY:			
		FEMALE	OFFICE USE ONLT:			
L						
IDENTITY NUMBER:			Kindly attach			
			copy of I.D.			
DATE OF BIRTH:		IN FORMAT CCYYMMDD	Document			
DATE OF BIRTH.		IN FORMAT CCT IMMIDD				
NAME OF PREVIOUS EMPLO	WED.					
NAME OF PREVIOUS EMPLO	YEK:					
NAME OF PREVIOUS MEDICA	AL AID —	MEMBERSH	IIP NO.:			
SCHEME(s) FOR THE PAST 2						
			Attach certificate(s) if			
PERIOD OF MEMBERSHIP F	ROM:	то:	more than one Scheme			
NAME OF EMPLOYER OF RUSINESS (If salf-omployed	·					
OR BUSINESS (If self-employed						
APPLICANT'S OCCUPATION						
DATE OF COMMENCEMENT	OF EMPL	VMENT. IN FORMAT CONVAMED				
DATE OF COMMENCEMENT	OF EMPLO	YMENT: IN FORMAT CCYYMMDD				
THE EDITONE NATIONED	III O TE					
TELEPHONE NUMBER:	[HOME]	-	Failure to advise date CAN result in pre-			
			existing ailments			
	[BUSINES	8]	being excluded.			

KINDLY COMPLETE IN FULL DETAIL HEALTH QUESTIONAIRE ON PAGE 3

<u>DEPENDANTS:</u>														
WIFE:														
SURNAME:														
FIRST NAME(S):														
IDENTITY NUMBER:											<	\		OTE:
DATE OF BIRTH:	IN FORMAT CCYYMMDD IN FORMAT CCYYMMDD Kindly attach copy of I.D. Documents and or Birth Certificates, Marriage Certificates										iments and Certificates,			
MARRIAGE CERTIFICATE NO.:					DATE:								and Clini all childre	ic Cards of en under the 10 years.
PLACE:													age of	To years.
CHILDREN:													7	7
FIRST NAMI [STATE SURNAME W		ENT]		M)ale F)emal		DATE OF BIRTH IN FORMAT CCYYMMDD						BIRTH CERT. NO. or IDENTITY NO.		
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MEMBER: SIGNAT	IGNATURE				EM				IPLOYER: SIGNATURE -					
FOR OFFICE USE ONLY														
MEMBERSHIP NO:							EN	IPLO	YER	NO:	J L			
DEPENDANTS:														
Registration Date:		T		Π		_								
Claim Qualification Date:														
Confinement Qualification														
Apprentice Date To:														

MEDICAL HISTORY OF APPLICANT AND DEPENDANTS: [COMPLETE ALL QUESTIONS]

ARE YOU OR YOUR DEPENDANTS SUFFERING FROM, OR HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING?

	QUESTION	ANS	WER	DEPE	ENDANT NAME
1	Any disorder of the heart e.g. Rheumatic fever, heart murmur, coronary artery disease, chest pain, shortness of breath or palpitations?	No	Yes		
2	High blood pressure, chronic headaches or disease of the blood vessels or circulatory disorder?	No	Yes		
3	Any respiratory or lung trouble, e.g. Asthma, Bronchitis, persistent cough, Tuberculosis?	No	Yes		
4	Any disorder of the digestive system, gall bladder or liver, e.g. Actual or suspected gastric or duodenal ulcer, recurrent indigestion or Hiatus Hernia?	No	Yes		
5	Disease or disorder of the kidneys, bladder or reproductive organs, e.g. Albumin in urine, stones, Prostatitis or Infertility?	No	Yes		
6	Any nervous or mental complaint, e.g. Epilepsy, Blackouts, Paralysis, anxiety state or depression, Alcoholism or Narcotism?	No	Yes		
7	Ear, eye, nose or throat disorder, e.g. Ear discharge, defective vision, Tonsillitis?	No	Yes		
8	Disorder or disease of muscles, bones, joints, limbs, spine, e.g. Rheumatism, Arthritis, Gout, slipped disc or back trouble?	No	Yes		
9	Diabetes, acne, sugar in urine, thyroid or other glandular or blood disorders?	No	Yes		
10	Cancer, growth or tumour of any kind?	No	Yes		
11	Any Tropical disease, e.g. Bilharzia?	No	Yes		
12	Any other illness, disorder, operation, disability or injuries from any accident?	No	Yes		
13	Any disorder of the female organs (breasts, ovaries, uterus) or any abnormality of pregnancy or confinement e.g. Caesarian section or miscarriage? If "Yes", state full details including dates.	No	Yes		
14	Any Orthodontic, Periodontic or Prosthodontic treatment?	No	Yes		
15	Any illness or physical defect likely to necessitate medical treatment, e.g. headaches, lumps, pain, etc.	No	Yes		
16	Detail all medication used by applicant and dependants during the last 2 years, as well as Pathology and Radiology tests.	No	Yes		
I	PLEASE STATE FULL NAME, ADDRESS AND TELEPHONE	E NUMB	ER OF U	SUAL MEDICAI	L PRACTITIONER
	POSTAL CODE		T	ELEPHONE NO	
FAIL	URE TO DISCLOSE MATERIAL INFORMATION OR THE PROVIS IMMEDIATE CANCELLATION O				ON CAN RESULT IN TH
MED quest are tr pay t Mana the ap	undersigned, hereby make application to the Management Committ ICAL AID FUND, EAST CAPE, and if admitted I agree to abide by the ionnaire or the non-disclosure of any material information will render use, correct and complete in every respect. I hereby authorize my emplohem to the Fund on my behalf. I confirm that I am employed by the igement Committee of any change in my state of health or that of my depolication. Consent is hereby given to approach any medical or dental ous medical or dental history.	Rules of my memb yer to dec e Employ pendants	the Fund. pership null luct from reer in a pe which occu	I declare that any full and void. I warra ny salary each mon rmanent capacity. rs prior to my rece	alse statement in the above ant that the above answe th the specified fees and I undertake to advise the iving written acceptance

MEMBER'S SIGNATURE

DATE:

WITNESS: SIGNATURE

DETAILS OF MEDICAL HISTORY

QUESTION NO.	DEPENDANT NAME	ILLNESS OR CONDITION	DATE AND DURATION OF ILLNESS/CONDITION	NAME OF HOSPITAL OR INSTITUTION	TREATMENT RECEIVED/RECOMMENDED AND DURATION OF TREATMENT